Appendix C

Centers for Medicare & Medicaid Services
Medicaid Integrity Program

DRAFT GLOSSARY

1. **ABERRANT PROVIDER**: A provider who inappropriately bills the Medicaid program and is consequently overpaid by the program.

2. **ABUSE:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. Also includes recipient practices that result in unnecessary cost to the Medicaid program.

3. **ACCEPTED REFERRAL**: Referral of a potentially fraudulent Medicaid provider to the State's Medicaid Fraud Control Unit (MFCU) that is accepted by the MFCU.

4. **ADMINISTRATIVE COSTS:** Expenses incurred for the general management and administration of an organizational unit.

5. **ADMINISTRATIVE DATA:** Data associated with administrative activities (e.g., enrollment or eligibility information, claims information, and managed care encounters).

6. **APPEAL**: A written request to a higher court to modify or reverse the judgment of a trial court, intermediate level appellate court, or state administrative action.

7. **AUDIT:** An assessment, evaluation, inspection, or investigation of services rendered or items furnished by a Medicaid provider.

8. **AUDIT REPORT:** A document that presents the scope, objectives, methods, data, findings, conclusions, and recommendations of an audit.

9. **AUDIT, COMPREHENSIVE:** Examinations of the adequacy, legality, honesty, and efficiency of the application of public funds. Such examinations involve not only individual fiscal transactions but also the financial management, internal controls, policies, and operating environments governing such transactions.

10. **AUDIT, DESK:** An audit that is wholly or principally carried out in the office(s) of the auditor.

DRAFT

11. **AUDIT, FIELD:** An audit that is carried out at the office(s) of the organization being audited or includes a substantial "on-site" component.

12. **AUDIT, FOCUSED**: An audit limited to a specific focus such as selected procedure code(s) or diagnosis.

13. **AUDIT, PROVIDER SELF:** An audit that is carried out wholly or principally by the provider being audited.

14. **BASELINE:** A specific quantity which can serve as an initial point of comparison.

15. **BENCHMARK:** A quantified goal to be achieved by an organization by a specific time.

16. **BENEFIT**: A service or item of value received by a beneficiary.

17. **BREACH:** A violation of State or Federal statute or regulation that results in Medicaid fraud, waste, and abuse.

18. **CAPITATION:** A payment that the State agency makes periodically to a managed care contractor on behalf of each recipient under a contract as compensation for the provision of medical services under the State plan.

19. **CASE:** An investigation by a Medicaid Program Integrity office, a Medicaid Fraud Control Unit, or other agency, to determine whether there has been a violation by a Medicaid provider of Medicaid laws, rules, or regulations or accepted standards.

20. **CIVIL MONEY PENALTIES:** Any penalty, fine, or other monetary sanction against individuals/entities for conduct that violates Federal and/or State statutes and regulations governing the Medicaid program.

21. **CLAIM:** A request for payment for services and benefits rendered by a Medicaid provider, also known as bills or invoices.

22. **CLAIMS REVIEW** - The review of a provider's Medicaid claims in order to determine whether the claims are complete, correct, and appropriately paid.

23. **CMS-64:** Form CMS-64 is a quarterly statement of expenditures for which States are entitled to federal reimbursement under Medicaid. Tracks expenditures for the quarter being reported and previous fiscal years, as well as collections or refunds received. Also the vehicle to report adjustments to correct overpayment and underpayment.

DRAFT

24. CLOSED-END PROVIDER AGREEMENT: An agreement for a specific period of time (e.g., not to exceed 12 months) that must be renewed in order to continue the provider's participation in the Medicaid program.

25. COLLECTIONS: Cash recovered in reimbursement of overpayments or other cash received as a result of Medicaid Integrity activities.

26. COMPLIANCE: Materially accurate and complete adherence to State rules on Medicaid billing, system requirements, and other federal or State regulations.

27. COMPLIANCE PROGRAM: Self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities.

28. CONVICTION: A judgment of guilt that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

29. COMPUTER MATCHING AGREEMENT: Any computerized comparison of two or more systems of records for the purpose of: (1) establishing or verifying eligibility or compliance with law and regulations of applicants or recipients/beneficiaries, or (2) recouping payments or overpayments.

30. COORDINATION OF BENEFITS: The process of determining the respective financial responsibilities of two or more health plans with respect to a medical claim.

31. CORE PROVIDER AGREEMENT: The basic contract that Medicaid holds with providers serving Medicaid recipients. The provider agreement outlines and defines terms of participation in the program.

32. COST AVOIDANCE: An action or intervention that reduce or eliminates a cost or outlay that would have occurred if not for that action or intervention.

33. COST REPORT: Report required from providers on an annual basis in order to make a proper determination of reimbursement rate under the Medicaid program based on the expenses incurred by the provider in the course of supplying services.

34. CREDENTIALING: Review procedures for purposes of determining whether a potential or existing provider meets certain standards that are a prerequisite for them to begin or continue participation in a given health care plan.

35. DATA MINING: The analysis of large volumes of data maintained in databases or data warehouses using query tools, algorithms, and models to identify patterns, trends, and relationships or correlations among the data and to develop useful information for investigative and management purposes.

DRAFT

36. DATA WAREHOUSE: A relational database designed for query and analysis, rather than for transaction processing. It usually contains historical data derived from transaction data, but can include data from other sources. It separates analysis workload from transaction workload and enables an organization to consolidate data from several sources.

37. DECISION SUPPORT SYSTEMS (DSS): A systematic collection of data, techniques, and supporting software and hardware by which an organization gathers and interprets relevant information from business and the environment and turns it into a basis for making management decisions.

38. DENIAL OF PAYMENT: The action of refusing payment of a claim, usually because of deficiencies in the claim.

39. DETECTION: Activities such as data mining, auditing, surveillance utilization and reviews or other methods, aimed at identifying possible fraud, waste, and abuse in the Medicaid program.

40. DISALLOWANCE: When a payer declines to pay for all or part of a claim submitted for payment. Usually synonymous with "denial of payment".

41. DISCLOSING ENTITY: Refers to the legally liable corporation/corporate officers identified on a State's "Disclosure of Ownership and Control Interest Statement" that furnishes services to the State Medicaid Agency.

42. DISTINCT PROGRAM INTEGRITY MODEL: Organizational structure in which a distinct Medicaid program integrity unit exists within the State. Medicaid Integrity activities such as prevention, detection, audit and investigation lie wholly within the State Medicaid Agency but are not necessarily centralized in a Medicaid "Program Integrity Unit."

43. DOLLARS IDENTIFIED FOR RECOVERY: Represents the dollar amount of claims inappropriately paid as identified by data mining, audit, surveillance utilization review or other methods.

44. DOLLARS RECOVERED: Represents total dollar amount of overpayments actually recovered by the State (as opposed to dollars identified or agreement by the provider to refund the program).

45. DOWNCODE: To reduce the monetary value and code of a claim when the documentation does not support the level of service billed by a provider.

DRAFT

46. DRUG UTILIZATION REVIEW (DUR) - Review of covered outpatient drugs that assures prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

47. DRUG UTILIZATION REVIEW, PROSPECTIVE (Pro-DUR): A process in which a request for a drug product for a particular recipient is screened, before the product is dispensed, for potential drug therapy problems.

48. DRUG UTILIZATION REVIEW RETROSPECTIVE (Pro-DUR): The process in which client's drug utilization is reviewed on a periodic basis to identify patterns of fraud, abuse, gross overuse, or inappropriate or unnecessary care.

49. DURABLE MEDICAL EQUIPMENT (DME): Purchased or rented items such as hospital beds, oxygen equipment, seat lift equipment, wheelchairs, and other medically necessary equipment prescribed by a health care provider.

50. EDITS: "Front end" reviews or controls in the Medicaid Management Information Systems (MMIS) that examine the information in each claim in relation to certain Medicaid policies and to other claims, and cause the claim to be paid, pended, or denied.

51. ELIGIBILITY: Refers to the process whereby an individual is determined by the State to be eligible for benefits through the Medicaid program.

52. ENCOUNTER DATA: Data related to the services and items received by a Medicaid recipient in an encounter with or visit to a Medicaid provider, whether on a fee-for-service or managed care basis. Also referred to as "shadow claims".

53. ENROLLMENT: The process of admitting (or not admitting) a prospective provider or recipient into the Medicaid program or a component of the program, such as managed care.

54. ENROLLMENT DATA: Refers to all pertinent data relating to a provider or recipient who has applied for enrollment in the Medicaid program.

55. EXCLUDED INDIVIDUALS OR ENTITIES: Individuals or entities that have been placed in non-eligible participant status under Medicare, Medicaid and other Federal or State health care programs. Exclusions may occur due to OIG sanctions, failure to renew license or certification registration, revocation of professional license or certification, or termination by the State Medicaid Agency.

56. EXCLUDED PARTIES LIST SYSTEM (EPLS): An electronic, web-based system maintained by the General Services Administration (GSA) that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. Can be found at http://www.epls.gov.

DRAFT

57. EXPEDITED PRIOR AUTHORIZATION: The process of obtaining authorization that must be used for selected services, in which providers use a set of numeric codes to indicate which acceptable indications, conditions, or diagnoses, and/or criteria are applicable to a particular request for services.

58. EXPENDITURE: Refers to funds spent as reported by the States.

59. EXPLANATION OF BENEFITS (EOB): A document sent to recipients that identifies items or services paid for by Medicaid and used to verify that the items or services were received.

60. EXTRAPOLATION: The process of predicting a future cost (or other measure) using current data or results from the past.

61. FALSE CLAIMS ACT (FCA): A law that is designed to reward any person who knows that an individual or company has financially defrauded the federal government by allowing that individual to file a "qui tam" lawsuit to recover damages on the government's behalf.

62. FEE-FOR-SERVICE (FFS): Traditional method of payment for medical services where payment is made to providers for each service rendered.

63. FISCAL AGENT: Entity that, through a contractual relationship with the State Medicaid or another State agency, receives, processes, adjudicates, and pays claims submitted by providers for items or services furnished under the State's Medicaid Program.

64. FOCUSED AUDIT: A review of services rendered or items furnished by a Medicaid provider that is limited in scope to a specific set of services or items or particular inappropriate billing practices.

65. FRAUD: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Includes any act that constitutes fraud under applicable Federal or State law.

66. FRAUD AND ABUSE DETECTION SYSTEM (FADS): A computer-based system employing various analytical software and methodologies to detect inappropriate billing or fraud by Medicaid providers.

67. FRAUD INVESTIGATION: An investigation of possible fraud that is conducted by State Medicaid Fraud Control Units or other investigative entities based on tips and referrals from providers, recipients, and other governmental agencies.

DRAFT

68. FRAUD INVESTIGATIONS DATABASE (FID): A comprehensive, nationwide system devoted to Medicare & Medicaid fraud and abuse and information-sharing process among government agencies, the FBI, DOJ, State MFCUs, Postal Inspectors' offices, Medicare contractors, and other program integrity stakeholders.

69. HEALTH PLAN: An individual or group plan that provides, or pays the cost of, medical care.

70. HEALTH CARE INTEGRITY PROTECTION DATA BANK (HIPDB): A national health care fraud and abuse data collection program for the reporting and disclosing of certain adverse actions taken against health care providers, suppliers and practitioners and for maintaining a database of final adverse actions taken against health care providers, suppliers and practitioners.

71. HYBRID MODEL: Organizational structure within a State in which the Medicaid Integrity activities are distributed across multiple bureaus, offices, or units throughout the State Medicaid Agency. There is no distinct Program Integrity unit. The State Medicaid Agency may conduct and supervise all prevention, detection, audit and investigation efforts for the Medicaid program, while the State's Offices of Mental Health, Alcohol/Substance Abuse Services, and/or Long-Term Care/Aging may also have their own payment integrity activities that are not under the direct control of the State's Medicaid Director.

72. INAPPROPRIATE PAYMENT: Any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirement.

73. INDIRECT COST: Costs that cannot be easily identified as directly resulting from a particular activity, service, or product but are necessary to the operation of an organization (e.g., staff salaries, rent, utilities).

74. INSPECTOR GENERAL (IG) MODEL: Organizational structure within a State in which a centralized Office of Inspector General (or equivalent) is independent of the Medicaid program. The IG unit conducts and supervises all prevention, detection, audit, and investigation efforts for <u>all</u> Medicaid payers (e.g., Medicaid program, Office of Mental Health, Alcohol/Substance Abuse, and/or Long Term Care/Aging Services).

75. INTERAGENCY AGREEMENT: An agreement or contract between or among two or more agencies.

76. **INTERNAL CONTROLS**: Procedures and activities that are intended to ensure that the operations of an organization are carried out in conformity with applicable laws, rules, regulations, policies, or procedures governing the organization.

77. **INVESTIGATION**: The analysis and gathering of evidence to support findings of suspected cases of fraud, waste and abuse by Medicaid providers.

78. **INVOLUNTARY DIS-ENROLLMENT:** Administration action by a State to terminate a provider's participation in the Medicaid program due to noncompliance with Medicaid rules, regulations, or payment policy and/or quality of care standards.

79. **JUDGMENT:** A court's final determination of the rights and obligations of the parties in a case.

80. **LIST OF EXCLUDED INDIVIDUALS AND ENTITIES (LEIE)**: List maintained by OIG of individuals and business excluded from participating in Federally-funded health care programs available at http://www.oig.hhs.gov/fraud/exclusions.html.

81. **MANAGED CARE**: A comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.

82. **MANAGED CARE ORGANIZATION (MCO):** An organization or entity that has a comprehensive risk contract under Medicaid to provide benefits to Medicaid recipients.

83. **MANAGED CARE OVERSIGHT:** Management and/or supervision of managed care organizations to ensure compliance with Medicaid rules, regulations, and policies.

84. **MEDICAID FRAUD CONTROL UNITS (MFCUs):** A functional entity, usually located in the offices of the State Attorney General, or other Department designated by the State, that investigates and prosecutes Medicaid fraud cases. Operates under a Memorandum of Understanding with the State Medicaid Agency and is subject to oversight by the DHHS' OIG.

85. **MEDICAID INTEGRITY:** Planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse.

86. **MEDICAID INTEGRITY PROGRAM:** Program established by the Deficit Reduction Act (DRA) of 2005 that provides the Centers for Medicare & Medicaid Services (CMS) with increased resources to prevent, identify, and recover inappropriate Medicaid payments. The two main operational responsibilities under

the program are: 1) reviewing the actions of those furnishing items or providing services under Medicaid and 2) providing effective support and assistance to States to combat Medicaid fraud, waste, and abuse.

87. MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS): An automated claims processing and information retrieval system required under the Medicaid program that produces service utilization and management information.

88. MEDICALLY NECESSARY: Services or supplies that are: 1) proper and necessary for the diagnosis or treatment of a medical condition; 2) provided for the diagnosis, direct care, and treatment of that condition; 3) meet the standards of good medical practice in the local area; 4) are not considered experimental; and 5) are not mainly for the convenience of a beneficiary or physician. Includes services or supplies that cannot be omitted without adversely affecting the individual's condition or the quality of medical care.

89. MEDICAL REVIEW: A review and evaluation of the medical records of a provider to determine the nature of the diagnosis, treatment, and medical procedures provided to a Medicaid recipient, if treatment and procedures were medically necessary, and whether proper administrative procedures and billing have been followed.

90. MEDICARE EXCLUSION DATABASE (MED): A file intended to assist States in screening providers and others for OIG exclusions. Contains a variety of identifiable and general information including name, Social Security Number, Employer Identification Number, UPIN, address, sanction type, and reinstatement date, if applicable. E-mailed to States every month. Files include the new month's sanctions, new reinstatements, cumulative sanctions, cumulative reinstatements and non-MED data. Also available through CMS' Application Portal.

91. NATIONAL PRACTITIONER'S DATABANK : A computerized data bank maintained by the federal government that contains information on physicians who have paid malpractice claims or against whom certain disciplinary actions have been taken.

92. NATIONAL PROVIDER IDENTIFIER (NPI): A standard, unique identifier for each provider of health care services, supplies, and equipment.

93. NEURAL NETWORK (ARTIFICIAL) ANALYSIS: Utilizes high-speed, high-volume technologies that approach real-time analysis of claim and encounter data to look for unexpected and suspicious patterns at the time of the claim transaction or data submission.

94. OFFSET: Withholding of funds from future provider payments to recover overpayments identified through Medicaid program integrity activities.

95. **OPEN-ENDED AGREEMENT:** An agreement or contract that does not have an ending date but will continue for as long as certain conditions, identified in the agreement, exist.

96. **OVERPAYMENT:** Any payment made to a Medicaid provider in excess of the payment to which the provider was entitled under State or federal laws and regulations.

97. **PAY AND CHASE**: Process by which the State Medicaid Agency pays the claim submitted by the Medicaid provider and then attempts to recover identified overpayments after conducting post-payment claims review.

98. **PERFORMANCE MEASUREMENT:** A gauge used to assess the performance of a process or function of any organization.

99. **POSTPAYMENT REVIEW:** The review of claims after payment has been made to the provider or beneficiary.

100. **PREDICTIVE MODEL:** A mathematical or statistical method for analyzing a body of data and predicting or forecasting future results or behavior.

101. **PRE-PAYMENT REVIEW:** Review of claims or invoices before payment is made.

102. **PREVENTION:** Activities to minimize the risk of fraud, waste, or abuse entering the payment system and activities used to educate Medicaid program staff and providers.

103. **PRIMARY CARE CASE MANAGEMENT (PCCM):** The health care management activities of a provider that contracts with the State to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services reimbursed on a FFS basis.

104. **PRIOR AUTHORIZATION:** A formal process by which, as a precondition for provider reimbursement, providers or recipients must obtain approval for certain medical services, equipment, or supplies (based on medical necessity) before the services are provided to recipients.

105. **PROVIDER:** Any person or entity enrolled in the Medicaid program that provides services and/or furnishes items that are billable under Medicaid.

106. **PROVIDER EDUCATION/COMMUNICATIONS:** Activities designed to educate and communicate with providers about Medicaid rules, regulations, and policies to ensure quality of care and payment integrity.

DRAFT

107. **QUI TAM LAWSUIT:** Civil fraud lawsuit filed by a private individual(s) on behalf of the government against entities and individuals that are defrauding the government (see "False Claims Act").

108. **RAMS II:** An advanced version of the mainframe Surveillance and Utilization Review Subsystem (SURS) system developed by a MMIS contractor.

109. **RECIPIENT:** An individual who receives benefits under the Medicaid program.

110. **RECOVERY**: Collections and offsets received from providers as a result of overpayments or other State program integrity activities.

111. **REFERRAL**: Information on potential provider fraud that is forwarded from the State Medicaid Agency to the Medicaid Fraud Control Unit (MFCU) or other State or federal investigative agency.

112. **RELIABLE**: Repeatable, stable, and consistent over time.

113. **RETURN ON INVESTMENT (ROI):** Savings/collections attributable to Medicaid program integrity efforts per dollar invested.

114. **RETROSPECTIVE REVIEW:** Review and evaluation of paid Medicaid claims and the health care records that support the claims to determine whether the payments were appropriate.

115. **SAVINGS:** Dollars recovered or recouped and dollars cost avoided due to Medicaid Integrity activities.

116. **SANCTION**: A penalty assessed on a Medicaid provider for a violation or violations of Medicaid laws, rules, regulations, or policies. May be in the form of a fine, suspension, termination, exclusion, civil monetary penalty, requirement for correction action, or other remedy/action.

117. **SETTLEMENT**: A negotiated agreement to collect identified overpayments from a Medicaid provider.

118. **SINGLE STATE AGENCY (SSA):** The single agency within the State responsible for the administration of the state Medicaid plan on behalf of the State.

119. **STANDARD OPERATING PROCEDURE:** An established procedure to be followed in a given situation.

120. **STATISTICAL SAMPLING:** Process of drawing a sample from a population, analyzing the sample, and making inferences concerning the population based on the sample.

DRAFT

121. STRATEGIC PLAN: A document used by an organization to align its policies and budget structure with organizational priorities, missions, and objectives. Should include a mission statement, a description of the agency's long-term goals and objectives, and strategies or means the agency plans to use to achieve these general goals and objectives. May also identify external factors that could affect achievement of long-term goals.

DRAFT

122. SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (SURS): A component of the Medicaid Management Information Systems designed to process information on medical and health care services to assist Medicaid program managers in identifying possible fraud and abuse by providers and Medicaid recipients. State SURS staffs perform data mining and other research for post-pay utilization review of providers and recipients in order to identify questionable patterns of service delivery and utilization.

123. SURS I: The early version of the mainframe-based SURS system developed in the late 1970's/early 1980's.

124. SURS II: An updated version of the mainframe-based SURS-I system.

125. SURS, ADVANCED: Advanced versions of the mainframe-based SURS-I and SURS-II systems.

126. SURS, PC-BASED: A client-server, PC-based system that can be operated through a dedicated network and that provides a place to store extensive SURS data, process SURS runs, and store reports. More user-friendly than traditional mainframe SURS (i.e., uses "point-and-click" technology and is capable of performing several functions at the same time) and allows users to perform analyses from desktops and receive relatively quick results.

127. SURS, CS-BASED: An advanced version of the PC-based SURS system.

128. SURVEY AND CERTIFICATION: Activity conducted by State agencies or CMS to determine whether prospective or current Medicaid providers meet the requirements for participation in the Medicaid program.

129. SUSPENSION OF PAYMENTS: The withholding of payment by a State Medicaid Agency to a provider or supplier before a determination of the amount of the overpayment exists.

130. TERMINATED PROVIDER: A provider who has been terminated from Medicaid program participation by the State Medicaid Agency due to program integrity concerns.

131. THIRD PARTY LIABILITY (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary.

132. TOTAL RECOVERIES: Dollars recovered from overpayments, settlements/judgments, and other collections (excluding TPL and prior authorization).

DRAFT

133. **UPCODING:** Billing for a more expensive Medicaid-covered service or item when a less expensive, non-covered service or item was provided.

134. **VALID:** Adequately represents the concept being evaluated.

135. **WHISTLEBLOWER:** An employee, former employee, or member of an organization who reports misconduct to people or entities that have the power and presumed willingness to take corrective action.

136. **WITHDRAWN PROVIDER:** A provider who has withdrawn from participation in the Medicaid program participation.

DRAFT